

classes after it receives written approval of the factors from CMS. CMS will give approval if it concludes that the factors can reasonably be used to predict the use of health services by individuals and families.

(1) An HMO must make a written request to CMS, listing the factors to be used in the community rating by class system under paragraph (b)(2) of this section.

(2) CMS will notify each HMO within 30 days of receipt of the request and application of one of the following:

- (i) The application is approved;
- (ii) Additional information or data are required and CMS will notify the HMO of its decision within 30 days from the date of receipt of this information or data; or
- (iii) CMS needs additional time to review the written request and the HMO will be notified of CMS's decision within 90 days.

(Approved by the Office of Management and Budget under control number 0915-0051)

(Sec. 215 of the Public Health Service Act, as amended, 58 Stat. 690, 67 Stat. 631 (42 U.S.C. 216); secs. 1301-1318, as amended, Pub. L. 97-35, 95 Stat. 572-578 (42 U.S.C. 300e-300e-17))

[45 FR 72528, Oct. 31, 1980, as amended at 47 FR 19339, May 5, 1982; 50 FR 6175, Feb. 14, 1985. Redesignated at 52 FR 36746, Sept. 30, 1987, as amended at 56 FR 8853, Mar. 1, 1991; 58 FR 38082, 38083, July 15, 1993]

#### **§417.105 Payment for supplemental health services.**

(a) An HMO may require supplemental health services payments, in addition to the basic health services payments, for the provision of each health service included in the supplemental health services set forth in §417.102 for which subscribers have contracted, or it may include supplemental health services in the basic health services provided its enrollees for a basic health services payment.

(b) Supplemental health services payments may be made in any agreed upon manner, such as prepayment or fee-for-service. Supplemental health services

payments that are fixed on a prepayment basis, however, must be fixed under a community rating system, unless the supplemental health services payment is for a supplemental health service provided an enrollee who is a full-time student at an accredited institution of higher education. In the case of an HMO that provided comprehensive health services on a prepaid basis before it became a qualified HMO, the community rating requirement shall not apply to that HMO during the forty-eight month period beginning with the month following the month in which it became a qualified HMO.

(Sec. 215 of the Public Health Service Act, as amended, 58 Stat. 690, 67 Stat. 631 (42 U.S.C. 216); secs. 1301-1318, as amended, Pub. L. 97-35, 95 Stat. 572-578 (42 U.S.C. 300e-300e-17))

[45 FR 72528, Oct. 31, 1980, as amended at 50 FR 6175, Feb. 14, 1985. Redesignated at 52 FR 36746, Sept. 30, 1987, as amended at 58 FR 38082, 38083, July 15, 1993]

#### **§417.106 Quality assurance program; Availability, accessibility, and continuity of basic and supplemental health services.**

(a) *Quality assurance program.* Each HMO or CMP must have an ongoing quality assurance program for its health services that meets the following conditions:

(1) Stresses health outcomes to the extent consistent with the state of the art.

(2) Provides review by physicians and other health professionals of the process followed in the provision of health services.

(3) Uses systematic data collection of performance and patient results, provides interpretation of these data to its practitioners, and institutes needed change.

(4) Includes written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services that ought to have been furnished have not been provided.

(b) *Availability and accessibility of health care services.* Basic health services and those supplemental health services for which enrollees have contracted must be provided or arranged

<sup>1</sup>Further information entitled "Guidelines for Rating by Class" may be obtained from the Office of Prepaid Health Care, Division of Qualification Analysis, HHS Cohen Bldg., room 4360, 330 Independence Ave. SW., Washington, DC 20201.

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for by the HMO in accordance with the following rules:

(1) Except as provided in paragraph (b)(2) of this section, the services must be available to each enrollee within the HMO's service area.

(2) *Exception.* If the HMO's service area is located wholly within a non-metropolitan area, the HMO may make available outside its service area any basic health service that is not a primary care or emergency care service, if the number of providers of that basic health service who will provide the service to the HMO's enrollees is insufficient to meet the demand. As used in this paragraph, primary care includes general practice, family practice, general internal medicine, general pediatrics, and general obstetrics and gynecology. An HMO that provides the services covered by these fields through at least a general or family practitioner, or a pediatrician and a general internist, is considered to be providing primary care.

(3) The services must be available and accessible with reasonable promptness to each of the HMO's enrollees as ensured through—

(i) Staffing patterns within generally accepted norms for meeting the projected enrollment needs; and

(ii) Geographic location, hours of operation, and arrangements for after-hours services. (Medically necessary emergency services must be available 24 hours a day, 7 days a week.)

(c) *Continuity of care.* The HMO must ensure continuity of care through arrangements that include but are not limited to the following:

(1) Use of a health professional who is primarily responsible for coordinating the enrollee's overall health care.

(2) A system of health and medical records that accumulates pertinent information about the enrollee's health care and makes it available to appropriate professionals.

(3) Arrangements made directly or through the HMO's providers to ensure that the HMO or the health professional who coordinates the enrollee's overall health care is kept informed about the services that the referral resources furnish to the enrollee.

(d) *Confidentiality of health records.* Each HMO must establish adequate

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procedures to ensure the confidentiality of the health and medical records of its enrollees.

[58 FR 38068, July 15, 1993]

### Subpart C—Qualified Health Maintenance Organizations: Organization and Operation

SOURCE: 58 FR 38068, July 15, 1993, unless otherwise noted.

#### § 417.120 Fiscally sound operation and assumption of financial risk.

(a) *Fiscally sound operation.*—(1) *General requirements.* Each HMO must have a fiscally sound operation, as demonstrated by the following:

(i) Total assets greater than total unsubordinated liabilities. In evaluating assets and liabilities, loan funds awarded or guaranteed under section 1306 of the PHS Act are not included as liabilities.

(ii) Sufficient cash flow and adequate liquidity to meet obligations as they become due.

(iii) A net operating surplus, or a financial plan that meets the requirements of paragraph (a)(2) of this section.

(iv) An insolvency protection plan that meets the requirements of § 417.122(b) for protection of enrollees.

(v) A fidelity bond or bonds, procured and maintained by the HMO, in an amount fixed by its policymaking body but not less than \$100,000 per individual, covering each officer and employee entrusted with the handling of its funds. The bond may have reasonable deductibles, based upon the financial strength of the HMO.

(vi) Insurance policies or other arrangements, secured and maintained by the HMO and approved by CMS to insure the HMO against losses arising from professional liability claims, fire, theft, fraud, embezzlement, and other casualty risks.

(2) *Financial plan requirement.* (i) If an HMO has not earned a cumulative net operating surplus during the three most recent fiscal years, did not earn a net operating surplus during the most recent fiscal year or does not have positive net worth, the HMO must submit a financial plan satisfactory to